HOUSE BILL 332
By Cepicky

SENATE BILL 308

By Hensley

AN ACT to amend Tennessee Code Annotated, Title 4; Title 56; Title 68 and Title 71, relative to managed care organizations.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, Part 1, is amended by adding the following as a new section:

(a) A recipient may choose a managed care organization when the recipient enrolls in the TennCare program or a successor program pursuant to the rules promulgated by the bureau.

(b) If a recipient does not choose a managed care organization pursuant to the rules promulgated pursuant to subsection (a), then the TennCare program or a successor program shall automatically assign the recipient to the managed care organization with the lowest number of active recipients until the membership among each managed care organization is no more than twenty percent (20%) greater or less than another. Once the membership among the managed care organizations is within twenty percent (20%), then the TennCare program shall assign recipients to the various managed care organizations on a rotating basis.

(c) The bureau shall promulgate rules to effectuate this section by July 1, 2023.

SECTION 2. Tennessee Code Annotated, Title 71, Chapter 5, Part 1, is amended by adding the following as a new section:

(a) A managed care organization (MCO) shall comply with federal centers for medicare and medicaid services (CMS) guidelines for medical loss ratio (MLR).

(b) For contract rating periods beginning on or after January 1, 2024, each managed care organization shall provide a remittance for an MLR reporting year. If the ratio for an MLR reporting year does not meet the minimum MLR standard required by CMS, then the bureau of TennCare shall determine the remittance amount on an MCO-specific basis and calculate the federal and nonfederal share amounts associated with each remittance. For the remittance funds collected in a fiscal year, the bureau shall:

(1) Return the federal share amounts from the remittance funds collected to the federal centers for medicare and medicaid services; and

(2) Deposit the remaining remittance funds into the general fund.

(c) The bureau shall post on its website the following:

(1) The aggregate MLR of all managed care organizations;

(2) The MLR of each managed care organization;

(3) The amount paid in remittance by each managed care organization in the last fiscal year; and

(4) Any required remittances owed by each managed care organization.

(d) For the purposes of this section:

(1) "Medical loss ratio reporting year" or "MLR reporting year" has the same meaning as that term is defined in 42 C.F.R. Section 438.8; and

(2) "Remittance" means the amount less than the medical loss ratio that is owed to federal or nonfederal entities.

SECTION 3. Tennessee Code Annotated, Title 71, Chapter 5, Part 1, is amended by adding the following as a new section:

(a) Beginning with the calendar year that begins January 1, 2024, the bureau of TennCare shall select all managed care organizations in accordance with this section, and shall not use a competitive bidding or request for proposal process.

(b)

(1) By January 1, 2024, the bureau of TennCare must contract with at least one (1) managed care organization (MCO) that is partnered with a provider participation entity (PPE), if the MCO and partnered PPE:

(A) Demonstrate the ability to fulfill TennCare MCO contract requirements; and

(B) Meet the eligibility requirements of subsection (c).

(2) Enrollment of recipients to and management of benefits from an MCO and partnered PPE contemplated in this subsection (b) must begin no later than January 1, 2024.

(c) To be eligible to contract with TennCare as a MCO partnered with a PPE:

(1) Either the MCO or the partnered PPE must:

(A) Have as its primary business purpose the ownership or operation of medicaid providers that can satisfy TennCare general access standards for primary care and physician and specialty care services in at least eighty percent (80%) of counties in this state;

(B) Demonstrate experience and capability managing an integrated healthcare network in this state that coordinates care across primary care, specialty care, hospitals, long-term care services, patient-centered medical homes, Tennessee Health Link providers, and behavioral health services;

(C) Demonstrate financial and quality improvement associated with care coordination;

(D) Demonstrate experience in data-sharing and integration, value-based care, risk assessment, medication management, utilization management, and care coordination;

(E) Demonstrate a commitment to address gaps in care by hiring additional providers in underserved communities; and

(F) Be licensed by the department of commerce and insurance; and

(2) The MCO must share risk for the financial outcomes of the PPE, including downside risk; and

(3) A majority of the PPE's governing body must be composed of individuals who serve in an administrative capacity within the provider partner or are licensed in this state as physicians, physician assistants, nurse practitioners, chiropractors, dentists, behavioral health services providers, or long-term care services providers.

(d) The bureau of TennCare shall submit to the commerce and labor committee of the senate and the committee of the house of representatives with oversight responsibility for TennCare all eligibility qualifications and standards developed for managed care organizations for approval by those committees.

(e) As used in this section:

(1) "Managed care organization" or "MCO" means a health maintenance organization, behavioral health organization, or managed health insurance issuer that participates in the TennCare program; and

(2) "Provider participation entity" or "PPE" means a healthcare network, business, or other entity:

(A) That maintains a statewide network of healthcare providers; and

(B) Which has an equity and voting position with the partner managed care organization.

SECTION 4. For the purpose of promulgating rules, this act takes effect upon becoming a law, the public welfare requiring it. For all other purposes, this act takes effect July 1, 2023, the public welfare requiring it.